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ABSTRACT

This document notes that it is commonly recognized that empathic attunement is vital if psychotherapy is to be truly therapeutic. It goes on to explain that, in spite of this recognition, therapists and clients alike will frequently demonstrate an anti-empathic attitude that indicates a basic opposition to understanding and being understood. In-session behavioral and experiential manifestations of this phenomenon are discussed, and many of the psychodynamics underlying the desire to avoid or destroy empathic understanding are identified. It is contended that this anti-empathic attitude occurs in many psychotherapy situations and accounts for the majority of psychotherapeutic failures. The first section of the paper deals with the patient's anti-empathic attitude, looking at in-session indicators that can help the therapist to identify when a client is resisting empathic connection, and discussing the underlying issues of self-esteem motives, guilt and self-punishment motives, and self-protective motives. Two case examples are included. A section on the therapist's anti-empathic attitude also examines in-session signs and underlying issues. Two case examples are given that demonstrate the therapist's unwillingness to provide a completed empathic circuit. Implications for interventions are discussed, and it is concluded that, when an anti-empathic attitude arises, it is the therapist's responsibility to recognize that the attitude exists and to intervene so as to repair the damaged empathic circuit. (NB)

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THE ANTI-EMPATHIC ATTITUDE IN CLIENTS AND THERAPISTS

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Abstract

It is commonly recognized that empathic attunement is vital if psychotherapy is to be truly therapeutic. Nevertheless, therapists and clients alike will frequently demonstrate an anti-empathic attitude that indicates a basic opposition to understanding and being understood. The in-session manifestations are discussed, as are many of the underlying issues that fuel this attitude.

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THE ANTI-EMPATHIC ATTITUDE IN CLIENTS AND THERAPISTS

Psychotherapy, when it is most potent and successful, is a remarkably simple and relatively clear cut interactive process:

(1) The client dares to divulge very personal details and feelings to the therapist.

(2) The therapist listens, empathically understands the client's statements and the affective contents.

(3) The therapist communicates these understandings.

(4) The client recognizes that the therapist truly understands.

This is the key interactive pattern that, when internalized by the patient over time, has the power to alter the intrapsychic structure of the patient's mind (Hager, 1989). Conversely, when psychotherapy becomes difficult, complex, and perplexing, we can assume that this essential process is being obstructed. Although being understood and understanding another is generally a gratifying experience, it can be just as terrifying, and because of this our work can become very difficult and complex.

This presentation is about the difficulties in understanding that we run into. I am speaking of the resistances that clients and therapists alike experience in their efforts to be understood and to understand. Note that I am emphasizing resistance, that is, anti-empathy or an anti-empathic attitude. I am not addressing misunderstanding, that is, when two people try to understand but miss the mark. In this talk I will address the in-session behavioral and experiential manifestations and many of the psychodynamics underlying the desire to avoid or destroy empathic understanding. This phenomenon occurs in many a psychotherapy and, in my estimation, accounts for the majority of psychotherapeutic failures.

THE PATIENT'S ANTI-EMPATHIC ATTITUDE

In-Session Signs

There are various in-session indicators that can help the therapist to identify when a client is resisting empathic connection. The patient may make only superficial disclosures or try to engage the therapist in light "chit-chat". The client may demonstrate an unflagging interest in the details of the therapist's life. The therapist may have reason to believe that the client is lying, telling half-truths, or misrepresenting himself or herself by offering only a grandiose or disgusting portrait of self. Incessant rationality, intellectualizing and excluding affect and fantasy also indicate resistances to empathic attunement. As Kahn (1986) and Modell (1975, 1980) have explained, in such instances the therapist will typically feel unbearably bored; this boredom being the result of limited affective

contact with the patient. Other signs of the patient's reluctance to disclose include rapid topical shifts, tangential side-tracking, chattering, and excessive silence. A patient's pleas for advice on how to be a different person frequently reflects an underlying resistance to being fully known.

A segment of clients who resist forming an empathic circuit due so by means of psychologically removing the therapist from the therapy arrangement. The client may not maintain eye contact. He or she may speak in a continuous monologue as if the therapist were merely a tape recorder. The client may disregard the therapist's statements; beginning each statement where he or she left off before the therapist began to speak. The therapist may feel irritated, used, and resentful.

A fairly common manifestation is the client's hair-splitting about the meaning of his or her disclosures: The client will reject all that the therapist understands with the claim that the therapist has actually not understood. On a few occasions I have experienced this phenomenon in its most ridiculous form where I have restated a client's disclosure verbatim, only to have it labeled by the client as inaccurate. Thinking that this may have been an indication that the client is unconsciously rejecting a superficial understanding on my part, I have offered "deep" interpretations, mid-depth interpretations, and transference interpretations, only to find the same oppositional response. Clearly these clients find it vitally important to maintain a sense of being misunderstood.

Underlying Issues

There are a number of common underlying issues that contribute to the anti-empathic stance. These issues or dynamics can be grouped into three motive categories:

(1) Self-esteem motives
(2) Guilt and self-punishment motives
(3) Self-protective motives

Self-Esteem Motives. The most frequently used explanation for patient resistances is that the patient is defending against conscious recognition of unconscious contents, either out of a fear of being overwhelmed, or due to a fear of punishment by the super-ego. Although this certainly is a major cause, there are many other motives that interfere with the establishment of a sound empathic circuit. One such instance is the patient's need to protect or bolster his or her self-esteem. This is the area of narcissism and perfectionism. Many a client will seek to impress or one-up the therapist--thus preventing authentic disclosure and understanding. For some, being clearly understood for who they are in their completeness is tantamount to humiliation: The threat of being understood and accepted as an imperfect being is experienced as admitting to worthlessness. These clients may experience the therapist as hunting for all that is unsavory and disgusting, eager to find fault and thus to degrade. These patients have a strong need

to sustain their precarious grandiosity, and thus will relax only when the therapist colludes to abandon true empathic connection. Of special note is the related issue of a man's need to protect his sense of masculinity in psychotherapy. Many clinicians (e.g. Bernardez, 1982; Scher, 1989; Werrbach & Gilbert, 1987) have noted that the traditional male role asks that men refrain from looking like "sissies" by sustaining the image of strength, self-containment, emotional control, and self-sufficiency. Consequently, a large portion of men in psychotherapy begin with--an often sustain--an anti-empathic attitude. The male patient's distancing in reaction to dependent feelings that are frequently stimulated in psychotherapy can also become a significant impediment to a secure empathic circuit.

Guilt and Punishment Issues. In An Outline Of Psychoanalysis Freud (1940) hypothesized that one of the most stubborn resistances is fueled by a patient's unconscious sense of guilt. According to Freud, the patient's guilt feelings militate against progress in the patient's treatment. The patient, in effect, needs his or her symptoms as a punishment. I have found that this phenomenon extends also to this area of empathy and understanding. When pushed, some patients will explain that their anti-empathic attitude owes to the conviction that they have no right to be understood. Being understood is a privilege afforded to other, more deserving people. Their own "badness" means having to bear the punishment of misunderstanding and non-acceptance. Such patients become acutely troubled following a fruitful, deep, and empathic session. They feel selfish, anxious, all the more guilty and ashamed, and subsequently attempt to short circuit whatever empathic connection has been established.

This type of patient more often than not reports a history of harsh treatment by parents, particularly characterized by the philosophy that "children are to be seen and not heard." Understanding was not a feature of the parent-child relationship; that is, aside from the parents insistence that the child understand the parent. When the patient finds the therapist dedicated to understanding the patient, the patient feels as though a major taboo is being broken. An unarticulate patient described the feeling aptly: "I feel like if I let you understand me, then I might feel closer to you then I do with my parents, that would be a betrayal."

Self-Protective Motives. Modell (1975, 1980) has noted that a good number of patients, predominantly with narcissistic personalities, actively and regularly exclude the therapist from their emotional experience and interactions as a form of self-preservation. As Modell explains it, the patient has built a protective "cocoon" around himself or herself in order to guard against the sense of annihilation by intrusion of another.

Some patients fear that the therapist will be disgusted and will ridicule, reject, or abandon the client if the client should become fully known. This is especially true if the client has any angry feelings toward the therapist. Some have a continuous expectation that they will always be misunderstood. Thus to guard against the pain of being passively misunderstood by another, the patient turns passive to active and presents himself or herself in an incomprehensible manner. Others have learned that to offer authentic information about one's self is tantamount to being controlled by another.

One of Mocell's (1980) patients "described feeling as if she were an egg: to share feeling was to crack herself open; the precious yolk would run out and be lost forever" (p. 262). Related to this is the fear that one will be completely swallowed up--all boundaries will cease to exist--and an autonomous self will cease to exist. These latter patients are more seriously disturbed and have come to believe that their very existance depends on being false.

Parenthetically, it should be noted that there are times when a patient's anti-empathic attitude does not emerge from transference, resistance, or the patient's unique psychopathology, but is instead a self-preserving reaction to the accurate perception of the therapist's pathology and/or inability to empathize.

Example A

Michael, a 31 yar old single man, sought treatment to overcome a prolonged depression that began three years earlier when a close friend of his died. Although Michael was able to make an initial link between the depression and his friend's death, he reported it all in a rationalizing and affectless monotone. The next two months were filled with superficial and intellectualized disclosures, frequent topic shifts, and not a word about his friend's death. It became clear to his (male) therapist that therapy would be fruitless if this anti-empathic process was allowed to continue. The therapist made a decision to address Michael's unwillingness to reveal himself, and Michael responded by revealing his fear of being seen as emotionally weak and dependent if he allowed his therapist to understand the depth of his pain. In discussing this, Michael was able to gain a degree of assurance and began sobbing uncontrollably. He then raised the topic of his friend's death, and this issue was subsequently dealt with numerous times over the following year of therapy. The therapy was judged to be productive and successful, with Michael's depression eventually lifting completely.

Example B

Kevin, a 21 year old single man, sought psychotherapy because of long-standing depression, isolation, and inability to form intimate relationships. Although not exhibiting grandiosity, Kevin demonstrated many characteristics of a narcissistic personality in that his sense of self was very fragile and prone to deflation upon the slightest hint of criticism. In sessions Kevin would divert his eyes from his therapist and disclose in a monologue-like fashion. He would frequently jump in with spontaneous talk just as his therapist was inhaling in preparation to speak. If by chance the therapist was able to voice her understanding, Kevin would respond with another monologue that had little or no relation to the therapist's comments. By the eighth session the therapist was feeling very annoyed, bored, and Kevin's depression had worsened. In the tenth

session the therapist addressed Kevin's avoidance of her empathic efforts. He responded by engaging in the first true dialogue of his therapy, and disclosed that he feared the potential annihilating effect that her words might have. What if she took him by surprise? What if she tried to scramble his mind? He was safe so long as he kept her away. Paradoxically, the therapist was able to develop and maintain an empathic circuit with him as long as the focus was on Kevin's anti-empathic stance. With time Kevin developed an ability to tolerate his fear of the therapist's perceptions of him, and he was able to achieve a fair amount in the course of his therapy.

THE THERAPIST'S ANTI-EMPATHIC ATTITUDE

Perhaps it is easier to recognize that patients frequently act so as to disrupt understanding. It is usually more difficult to see that therapists frequently do not wish to understand their patients. Nevertheless, it is certainly true. I am not speaking of simple misunderstanding, but of an attitude of resistance to understanding the patient.

In-Session Signs.

The therapist's anti-empathic attitude is typically manifest as an inability or unwillingness to listen to and/or understand all that the client is trying to communicate. The refusal to communicate understandings to the patient is also typical. One sign that an anti-empathic attitude may be in operation is discomfort in simply being with the patient. The therapist may find that he or she is wishing that the client would radically and rapidly change. The therapist may find himself or herself becoming highly directive, giving advice, pep talks, or trying to quiet the client, especially when the client is disclosing strong emotion. Trying to get the client to be more rational is another sign that the therapist is having difficulty in listening to the client. Related to this is the phenomenon of trivializing or refusing to recognize the strength of the client's conflicts and pain. The therapist may attempt to place "bandaids" on major wounds with the aim of convincing the client that she or he really has no problem at all.

Another indicator of a therapist's anti-empathic attitude is a heavy reliance on theory to conceptualize the client's problems. The therapist may also find himself or herself promoting superficiality by pontificating, using a lot of psychological jargon with the client, or engaging in "chit-chat". Similar to this is not taking measures to create a secure therapy environment. Not beginning or ending sessions on time and discussing other clients are examples. I have even known of a therapist who frequently conducted interviews with the door open. If we are all honest with ourselves, we will all recognize the wish that a client will no show or drop out of therapy. All of these behaviors can be taken as signs of a resistance to understanding the client.

Some Underlying Issues

Perhaps the most frequent cause of anti-empathic responses in therapists is the fear of the unknown or the fear of being overwhelmed by feeling. This often is manifested as a more recognizable fear that the client will completely regress, become psychotic or overwhelmed. When this occurs it is often the case that the clients' conflicts parallel those of the therapists, either consciously or unsconsciously.

A therapist may also unconsciously reject aspects of the clients' experience or life due to similar treatment by the therapist's parents when he or she was a child. Thus if the therapist learned that hurt, anger, jealousy, joy, etc., were disgusting and unallowed, then the therapist may react to these affective disclosures on the client's part with disgust and unwillingness to listen. The flip of this is an envy, either conscious or unconscious, of aspects of the client's life that the therapist has yet to achieve or allow himself or herself to experience.

Another major class of issues that works against understanding is the problem of therapist narcissism. A therapist may feel a need to prove beliefs and theories via the client. The therapist may be personally insecure, and find it necessary to continuously assert his or her positions and opinions, thus ignoring and discounting the disclosures of the patient. Such a therapist may also develop an anti-empathic attitude due to narcissistic retaliation: The patient's experience and disclosures are rejected, overtly or in a more disguised form, because of the wound the therapist has experienced as a consequence of the patient's rejections of the therapist's interpretations. In such a situation listening to and understanding the patient is the furthest thing from the therapist's mind. Instead, the therapist's aim is to convince the patient that he or she knows better.

Another narcissistic issue has to do with sexual identity issues of male therapists. Nurturance and understanding is not a component of the traditional male sex role, but a component of the feminine sex role. Thus many male therapists have difficulty in seeing themselves as understanding and nurturant beings, and instead see their role as an allopathic surgeon-like agent of change. To adopt an understanding role is sometimes felt by male therapists as being subservient and thus feminine.

Harsh training experiences can also lead to severe anti-empathic attitudes. Parallel process works both ways. The therapist who has been emotionally traumatized by a narcissistic or overly harsh supervisor will frequently pass along such treatment to his or her patients. Frequently such therapists will acquire the belief that there is one correct way to do psychotherapy and the patient's failure to fit that mold exactly leads to accusations of patient resistance. Some therapists develop overly rigid interpretations of various theoretical positions. For example, I have frequently found that therapists will misinterpret Freud's (1919) principles of neutrality and abstinance to mean that the client should not be gratified at all, and particularly by understanding.

The last issue I would like to mention is the therapist's fear of damaging the patient with the truth. In this situation the therapist does indeed listen and understand, but blocks the completion of an empathic circuit by refusing to communicate this understanding to the patient. The therapist may believe that the patient will deteriorate upon hearing this understanding or may believe that it is the therapist's job to protect the patient's self-esteem. The therapist who withholds this understanding is, in effect, indirectly attributing ego-weakness to the patient. The therapist is demonstrating the belief that the patient is unable to cope with the truth, and this is a demonstration of the lack of faith the therapist has in the patient. Although the therapist does indeed understand there is nevertheless an anti-empathic attitude in operation, for the therapist is unwilling to provide a completed empathic circuit.

Example C

Mary, a 33 year old married woman, sought treatment to work through a plethora of issues associated with her father's sexual abuse of her. An empathic circuit formed rapidly and was maintained during the early weeks of her therapy. During this period she and her therapist discussed the tremendous rage she felt toward her father, her murderous and castrating fantasies, and the guilt she felt as a consequence of these fantasies. At the tenth session she became agitated, and this persisted for the following two weeks. She then offered new information to her therapist: that a portion of the guilt she felt was due to being "pretty sure" that occasionally she enjoyed the sex with her father. Up until that point the therapist was able to empathize with her feelings, but this new information left him anxious, disbelieving, and he told Mary that she was mistaken. Incest is abuse, he asserted, and her belief that she enjoyed it was merely her attempt to protect her father from her rage at him. At that point the empathic circuit was broken. Mary attended two more sessions. She was depressed and offered only superficial disclosures. She then dropped out of therapy and was not heard from again.

Example D

Rebecca, a 36 year old married woman, sought a one-session consultation with a psychologist because of a lack of progress in her therapy of two and one-half years. She explained that she suffered from lifelong and unremitting daydreaming. The problem had become so extreme that she would wake herself each night in order to fantasize. She was very secretive about it, and would spend as much time as she could in the basement and bathroom in order to prevent detection by her husband. She also explained that she was terrified of the prospect of anyone ever learning about the content of her fantasies, and in two and one-half years of therapy not once did she ever divulge this information, nor did her therapist ever inquire! Instead, the therapist worked to have her divert her attention from her fantasies---a

strategy that was clearly not effective and which prevented the formation of a secure empathic circuit. The consulting psychologist advised her to raise the issue with her therapist, and seek a different clinician if her therapist failed to address the content of her fantasies.

This example illustrates a collusive or shared anti-empathic attitude, but the responsible party was primarily the therapist. The client was clearly hinting at her simultaneous wish for and fear of understanding. She required an invitation and prompting. The therapist, however, was evidently unwilling or unable to do this for her.

IMPLICATIONS FOR INTERVENTION

From the perspective described in this paper the therapist's job is two-fold: First, the therapist is required to listen to and understand the patient and thus to do his or her part in developing and maintaining a secure empathic circuit. Second, the therapist is required to monitor the empathic circuit and intervene when breaks in the circuit arise. When in-session signs of an anti-empathic attitude exists, it is the therapist's responsibility to address this as a problem. If the anti-empathic attitude exists primarily for the therapist, it is imperative that the therapist be honest with himself or herself, try to understand the source of this attitude, and work to overcome the negative impact it is having on the therapy arrangement. When the patient is demonstrating an anti-empathic attitude, it is the therapist's responsibility to point this out and probe for the reasons behind the patient's resistence to being understood. By helping the patient to verbalize his or her experience, the therapist is simultaneously repairing the empathic circuit.

How does a therapist know if the empathic circuit is intact or damaged? When the therapist is confused, frustrated, bored and begins to see the patient as a very complex case, the chances are very good that a break in the circuit exists at one or more points. The therapist would do well to review in his or her mind the four points the comprise the empathic circuit: Is the patient disclosing undefensively? Is the therapist listening and clearly understanding? Is the therapist clearly communicating this understanding to the patient? Is the patient clearly recognizing the understanding the therapist has? An unremitting "no" to any of these questions indicates that an intervention of some sort is necessary.

SUMMARY

The success of any psychotherapeutic arrangement depends upon the presence of a particular fundamental interaction pattern that has been labeled the empathic circuit. Specifically, the therapist must empathically understand the client's personally significant disclosures and must communicate this understanding to the client in a clear and nonpejorative manner. The client, in turn, must reveal himself or herself by disclosing personally significant material and must remain open to and recognize the therapist's empathic understanding. One of the major barriers to the formation or maintenance of a secure empathic circuit is the anti-empathic attitude: a mental-emotional set that reflects a resistence to a goal of understanding the client's inner world. Clients and therapists alike may develop this attitude for one reason or another; the effect being a reduction or destruction of the benefits of psychotherapy. When this attitude arises, it is the therapist's responsibility to recognize that the attitude exists and to intervene so as to repair the damaged empathic circuit.

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